Barriers to Domestic Violence Screening in the Pediatric Setting

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ABSTRACT. *Objective.* **By surveying practitioners in our community, we hoped to determine what pediatricians and family physicians (FPs) perceive as barriers to the American Academy of Pediatrics (AAP) Recommendation on Domestic Violence Screening.**

Background. **When screened in the pediatric setting, as many as 40% of mothers will disclose domestic violence (DV) by their partner. Recognizing the profound effects of DV on children, the AAP recently recommended that all practitioners incorporate DV screening as a part of routine anticipatory guidance. Yet, there is little information about whether pediatricians have the training, the time to screen, or understand the magnitude of this problem.**

Design/Methods. **A 22-question survey about attitudes, training, and current DV screening practice was sent to all general pediatricians and FPs with admitting privileges to Children's Hospital Medical Center in Cincinnati, Ohio. A copy of the AAP recommendation on screening was included. The vast majority of practitioners with an appreciable pediatric practice in the surrounding tri-state area of 1.8 million people have privileges at the institution.**

Results. **After 2 mailings, 310 (57%) of 547 of questionnaires were returned. The majority of practitioners (64%) were unaware of the AAP recommendation, but 51% of practitioners screened at least high-risk families for DV and 49% had identified a case of DV in their practice. Still, only 8.5% routinely screened for DV and 74% had received no specific DV training. Fifty-eight percent of practitioners estimated the incidence of DV to be <5% in their practice. The most commonly perceived barriers to screening were lack of education (61%), office protocol (60%), time (59%), and support staff (55%). FPs were significantly more likely to have DV training (64% vs 21%), more likely to screen at least high-risk women (79% vs 56%), and more likely to have identified a case of DV (92% vs 40%) than pediatricians. FPs were less likely to cite lack of education (46% vs 65%) and lack of time (50% vs 61%) than pediatricians. Physicians licensed in Ohio were less likely to have specific domestic violence training (23% vs 60%) as compared with Kentucky physicians, where domestic violence education is required for licensing. Kentucky physicians were less likely to cite lack of education as barrier to DV screening (20% vs 62%). When comparing the characteristics of those who screen to those who do not, those with DV training were 10.9 times (odds adjusted ratio) more likely to screen.**

Conclusions. **Practitioners grossly underestimate the incidence of DV in their practices. Lack of education including knowledge of screening recommendations is a barrier to DV screening by pediatricians. Greater efforts are needed to educate pediatricians on DV for the AAP recommendations to be accepted.** *Pediatrics* **2001; 108:98–102;** ***domestic violence, child abuse, screening, physician attitude.***

ABBREVIATIONS. DV, domestic violence; AAP, American Academy of Pediatrics; FP, family practitioner; CHMC, Children's Hospital Medical Center.

When screened in the pediatric setting, as many as 40% of mothers will disclose domestic violence (DV) by their partner.[1–4] Children who witness DV are at risk for developmental delay, sleep disorders, school failure, oppositional defiant disorder, depression, and other psychiatric disorders.[5–10] Sadly, children in these homes are often abused themselves.[8,11–15] Recognizing the profound effects of DV on children, the American Academy of Pediatrics (AAP) recently recommended that all practitioners incorporate DV screening as a part of routine anticipatory guidance.[16] Yet, there is little information about whether pediatricians have the training, the time to screen, or understand the magnitude of this problem.[1]

Barriers to screening for DV have been identified in emergency medicine, obstetric, and family medicine literature. The barriers cited include lack of education and training, fear of "opening Pandora's box," lack of time, belief that it is not the physician's role, and difficulty dealing with women's feelings, among others.[14,17–27] An understanding of barriers specifically perceived by pediatricians and family practitioners (FPs) who care for children could potentially lead to better compliance to the AAP recommendation. Our study was designed to assess the DV training, experience, and screening practices of pediatric providers in our community and to determine what they perceive as barriers to screening.

METHODS

A 22-item questionnaire was developed to collect current attitudes, practices, and barriers regarding screening for domestic violence. The survey was distributed to all general academic faculty, pediatric residents, FPs, and community pediatricians on the medical staff at Children's Hospital Medical Center in Cincinnati,

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Ohio (CHMC). CHMC is the only significant inpatient pediatric facility for a community of 1.8 million. Virtually all practitioners with an appreciable pediatric practice are on the CHMC medical staff. The staff includes physicians who practice in Indiana, Kentucky, and Ohio. Primary care physicians practicing in Kentucky are required to take a 3-hour course on DV to maintain their medical license. The survey was sent with a cover letter to assure anonymity and explain the purpose of our study. DV was defined as any act in which 1 adult partner physically injures the other partner or when an adult partner fears physical injury from the other. Also included was a copy of the AAP release in June 1998 *Pediatrics*, "The Role of the Pediatrician in Recognizing and Intervening on Behalf of Abused Women".[16] Surveys were returned by addressed, postage-paid envelopes that were sent with the questionnaires.

The DV Screening Survey had 3 parts. The first part of the questionnaire contained demographic information such as age, gender, state(s) of practice, years in practice, and current status as a pediatric resident, academic pediatrician, private pediatrician, or FP. The second part of the survey was designed to assess DV screening behavior and knowledge with the questions outlined in Tables 2 and 3.

Regarding the analytical methods, *SPSS Version 7.5* (SPSS Inc, Chicago, IL) was used to analyze this data set. Logistic regression was performed to determine if physician specialty, age, gender, state, or screening practice were statistically related to the survey responses.

RESULTS

After 2 mailings 1 month apart, 310 (57%) of 547 of questionnaires were returned. Demographic characteristics of respondents are outlined in Table 1. Of the respondents, 42% identified themselves as female, 48% as private pediatricians, 37% as between 30 to 39 years old, and 71% as practicing in Ohio.

TABLE 1. Characteristics of Respondents

Characteristic	*n*	(%)
Physician specialty		
Pediatric resident	84	(27.1)
Private pediatrician	150	(48.4)
Academic pediatrician	20	(6.5)
FP	52	(16.8)
Missing	4	(1.3)
Age		
<30 y	65	(21.0)
30–39 y	115	(37.1)
40–49 y	82	(26.5)
50–59 y	29	(9.4)
60+ y	16	(5.2)
Missing	3	(1.0)
Gender		
Male	110	(35.5)
Female	129	(41.6)
Missing	71	(22.9)
Number of years practicing medicine		
0–5 y	119	(38.4)
6–10 y	46	(14.8)
11–15 y	40	(12.9)
16–20 y	25	(8.1)
21–25 y	14	(4.5)
26–30 y	15	(4.8)
31+ y	12	(3.7)
Missing	39	(12.6)
State*		
Kentucky (KY)	33	(10.6)
Ohio (OH)	221	(71.3)
Indiana (IN)	10	(3.2)
KY Only	15	(4.8)
OH Only	203	(65.5)
KY and OH	18	(5.8)
Neither KY or OH; missing	74	(23.9)

* States listed do not represent mutually exclusive categories.

TABLE 2. Responses to Questions Related to Domestic Violence Screening

Survey Questions	Yes		No	
	n	(%)	*n*	(%)
Have you ever identified a case of DV in your practice?	152	(49.2)	157	(50.8)
Have you ever reported a case of DV?	102	(33.1)	206	(66.9)
Have you ever identified a case of child abuse in your practice?	230	(74.4)	79	(25.6)
Have you ever reported a case of child abuse?	227	(73.7)	81	(26.3)
Are you aware of AAP recommendations regarding screening for DV?	111	(35.9)	198	(64.1)
Would you consider yourself knowledgeable about DV laws in your state?	90	(29.1)	219	(70.9)
Would you consider yourself knowledgeable about child abuse laws in your state?	207	(67.6)	99	(32.4)
Are you aware of resources in your area for victims of DV?	184	(60.1)	122	(39.9)
Do you currently screen for violence in families as part of anticipatory guidance?				
No			123	(40.1)
Yes, but high risk only			158	(51.5)
Yes, all patients			26	(8.5)
Have you had any specific training about DV?				
No			107	(73.6)
Yes, <2 h			0	(0.0)
Yes, 2–4 h			31	(13.4)
Yes, 5+ h			30	(13.0)
What do you estimate the incidence of DV to be in your practice?				
<1%			5	(1.7)
1–5%			162	(56.3)
6–10%			69	(24.0)
11–15%			30	(10.4)
16+%			22	(7.6)

The responses to questions related to DV are listed in Table 2. Only 49% had ever identified a case of DV in their practice, whereas 74% had identified child abuse. The majority of practitioners (64%) were unaware of the AAP recommendation, but 51% of practitioners screened at least high-risk families for DV. Still, only 8.5% routinely screened for DV, 74% had received no specific DV training, and 71% considered themselves as not knowledgeable about the state laws regarding DV. Fifty-eight percent of practitioners estimated the incidence of DV to be <5% in their practice. Only 8% estimated the incidence to be >16%.

Table 3 includes the responses related to potential barriers to screening for DV. The most commonly perceived barriers to screening were lack of education (61%), office protocol (60%), time (59%), and support staff (55%). Insufficient referral sources (70%) and lack of confidence in the legal system (45%) were not barriers. Sixty percent of responders were comfortable assessing degree of danger in a home, and 86% were comfortable educating women. Other barriers that received comment included the following: "women deny that it is a problem"; "high patient resistance to problem"; and several statements regarding lack of patient continuity in their practice resulting in less intimate patient–doctor relationships.

TABLE 3. Responses Related to Potential Barriers to Screening for DV

Potential Barrier	Yes		No	
	n	(%)	*n*	(%)
Lack of physician education regarding DV and/or child abuse	190	(61.3)	120	(38.7)
Lack of office protocol	185	(59.7)	125	(40.3)
Insufficient or inadequate referral sources	93	(30.0)	217	(70.0)
Discomfort assessing degree of danger in household	125	(40.3)	185	(59.7)
Discomfort educating about available resources	44	(14.2)	266	(85.8)
Lack of time	184	(59.4)	126	(40.6)
Lack of confidence in legal system	82	(26.5)	228	(73.5)
Lack of support staff to assist in victim education, safety planning, legal advocacy, and the referral process	170	(54.8)	140	(45.2)
Other barriers specified	8	(2.6)	302	(97.4)

Table 4 illustrates positive responses to survey questions by physician specialty. Private pediatricians were less likely to have had specific training about DV and were more likely to experience discomfort assessing DV. Academic pediatricians were more likely to have identified a case of child abuse and were more likely to be aware of the AAP recommendations. Family practitioners were more likely to have identified a case of DV, reported a case of DV, know the DV laws in their state, be aware of local DV resources, currently screen at least high-risk patients, and were more likely to have had specific training about DV. Family practitioners were less likely to cite the following barriers to DV screening: lack of education, discomfort assessing DV, lack of time, and lack of support staff.

Regression analyses with responses to survey questions by age are outlined in Table 5. Of significance, physicians <30 years old were less likely to have identified a case of DV, have reported a case of DV, be aware of AAP recommendations, know the DV laws in his/her state, know the child abuse laws in his/her state, and be aware of local DV resources. Physicians <30 years old were more likely to cite lack of physician education as a potential barrier to DV screening. Doctors between 30 and 39 years of age were less likely to know the child abuse laws in their state and were less likely to cite discomfort assessing DV in the household and educating women about resources as barriers to DV screening. Practitioners between 40 and 49 years of age were more likely to identify lack of confidence in the legal system as a barrier to DV screening. Those between 50 and 59 years were more likely to have identified and reported a case of DV.

Responses to survey questions by state are shown in Table 6. Physicians practicing in Kentucky were more likely to know the DV laws in their state and were less likely to cite lack of physician education as a potential barrier to screening for DV. Ohio physicians were less likely to have had specific training about DV and were more likely to cite lack of physician education as a barrier to screening.

When comparing responses by gender, males were more likely to be aware of the AAP recommendations than females ($P < .05$). Female physicians were more likely to estimate the incidence of DV in their practice to >10% ($P < .05$). There were no other significant differences with regards to gender.

Comparing the characteristics of those who screened to those who did not screen, showed that screeners were 10.9 times more likely to have DV training (odds adjusted ratio, $P < .001$, 95% confidence interval: 3.79–31.58) and more likely to be aware of the AAP DV screening recommendations (odds adjusted ratio 2.59, $P < .01$, 95% confidence interval: 1.27–5.27). When looking at barriers to screening, screeners were less likely to cite lack of education as a barrier (odds adjusted ratio 0.33, $P < .0001$, 95% confidence interval: 0.20–0.57). Screeners were more likely, however, to cite insufficient referral resources as a barrier to screening (odds adjusted ratio 1.9, $P < .05$, 95% confidence interval: 1.09–3.41).

DISCUSSION

Multiple investigators have reported the benefits of screening women for DV in the emergency, obstetrical, family practice, and internal medicine setting.[19,25–35] Barriers to screening with these specialists have been well described.[14,18–27] Screening in the pediatric setting may offer unique opportunities. In a previous report, we described women with young children who were abused during pregnancy as a group that can be successfully identified at pediatric well visits.[1] Thus, the pediatric provider has a unique opportunity to intervene in with these high-risk families. Our study suggests, however, that pediatricians lack the training for this task and grossly underestimate the magnitude of this problem.

Similar to other reports, the majority of our respondents chose lack of time, education, and office protocol as barriers to screening. FPs on staff were more likely to already be screening, have had specific DV training, and to be aware of local DV resources and laws. This more educated and experienced group was less likely to cite lack of time as a screening barrier. This implies that time may be less of a factor once pediatricians gain more experience screening. Although FPs were more likely to screen for DV, pediatricians were more likely to have identified a case of child abuse. This may reflect that FPs are more comfortable with problems relating directly to adults and pediatricians with problems directly related to children.

Lack of education proved to be a major issue for our study group. Less than 25% of physicians had any specific DV training. The majority of physicians were unaware of the AAP recommendation on DV screening and less than a third knew their states' DV laws. Our results showed that those who had DV training were far more likely to screen than those who did not. Kentucky physicians who practice in a state which requires a 3-hour DV training course were more likely to have DV training and know their state laws, and less likely to cite lack of education as a barrier to screening. Although not statistically significant, more Kentucky physicians were screening for DV. Kentucky's educational effort seems to be having a positive effect. Of great concern was the

TABLE 4. Significant Positive Responses to Survey Questions by Specialty

	Pediatric Resident (n = 84)		Private Pediatrician (n = 150)		Academic Pediatrician (n = 20)		Family Practitioner (n = 52)	
	n	(%)	n	(%)	n	(%)	n	(%)
Survey question								
Identified a case of DV	19	(22.6)	73	(48.7)	9	(45.0)	48	(92.3)*
Reported a case of DV	13	(15.5)	53	(35.3)	7	(35.0)	26	(50.0)*
Identified a case of child abuse	50	(59.5)	122	(81.3)	19	(95.0)**	36	(69.2)
Aware of AAP recommendations	15	(17.9)	61	(40.7)	12	(60.0)**	21	(40.4)
Know state DV laws	12	(14.3)	46	(30.7)	5	(25.0)	26	(50.0)*
Aware of local DV resources	24	(28.6)	98	(65.3)	12	(60.0)	48	(92.3)*
Currently screen at least high risk	47	(56.6)	83	(55.7)	10	(52.6)	41	(78.8)*
Had specific DV training	14	(25.5)	22	(17.6)*	4	(26.7)	21	(63.6)*
Potential barriers to DV screening								
Lack of physician education	65	(77.4)	88	(58.7)	11	(55.0)	24	(46.2)**
Discomfort assessing DV in household	38	(45.2)	67	(44.7)**	6	(30.0)	12	(23.1)**
Lack of time	52	(61.9)	88	(58.7)	16	(80.0)	26	(50.0)**
Lack of support staff	46	(54.8)	88	(58.7)	14	(70.0)	20	(38.5)*

* $P < .01$.
** $P < .05$.

TABLE 5. Positive Responses to Survey Questions by Age

	<30 Years (n = 65)		30–39 Years (n = 115)		40–49 Years (n = 82)		50–59 Years (n = 29)	
	n	(%)	n	(%)	n	(%)	n	(%)
Survey question								
Identified a case of DV	12	(18.5)*	60	(52.2)	48	(58.5)	20	(69.0)**
Reported a case of DV	8	(12.3)*	41	(35.7)	28	(34.1)	15	(51.7)**
Aware of AAP recommendations	12	(18.5)*	36	(31.3)	38	(46.3)	16	(55.2)
Know state DV laws	11	(16.9)*	34	(29.6)	24	(29.3)	9	(31.0)
Know state child abuse laws	29	(44.6)*	74	(64.3)**	62	(75.6)	24	(82.8)
Aware of local DV resources	16	(24.6)*	76	(66.1)	58	(70.7)	19	(65.5)
Potential barriers to DV screening								
Lack of physician education	51	(78.5)*	69	(60.0)	47	(57.3)	16	(55.2)
Discomfort assessing DV in household	30	(46.2)	35	(30.4)**	40	(48.8)	14	(48.3)
Discomfort educating about resources	14	(21.5)	8	(7.0)*	12	(14.6)	7	(24.1)
Lack of confidence in legal system	13	(20.0)	26	(22.6)	31	(37.8)*	10	(34.5)

There were no statistically significant responses in 60+ years grouping.
* $P < .01$.
** $P < .05$.

TABLE 6. Significant Positive Responses to Survey Questions by State

	Kentucky (KY) (n = 15)		Ohio (OH) (n = 203)		Both (KY and OH) (n = 18)		Neither or Missing (n = 74)	
	n	(%)	n	(%)	n	(%)	n	(%)
Survey question								
Know state DV laws	9	(60.0)**	60	(29.6)	9	(50.0)	12	(16.2)
Had specific DV training	6	(60.0)	37	(23.1)*	8	(61.5)	10	(20.8)
Potential barriers to DV screening								
Lack of physician education	3	(20.0)**	125	(61.6)**	6	(33.3)	56	(75.7)

finding that younger physicians felt lack of education was a barrier to screening. Clearly, residency training programs need to address this issue more effectively.

Also, we determined that those who actually screen were more likely to cite insufficient referral resources as a barrier to screening. This strongly suggests that this type of resource needs to be more readily available to physicians for screening to be successful.

Our practitioners grossly underestimated the incidence of DV. Eighty-two percent of practitioners in the study estimated the incidence of DV as <10% in their practice. Estimates from recent studies are likely low because many victims do not reveal their abuse on initial questioning. Despite this, studies by Siegel and Wissow[1,4] each report the incidence of DV as 31% and 40%, respectively. Duffy reports that 52% of women screened reported a history of adult physical abuse.[2]

Our study has limitations. One limitation is that the response rate was <60%. Because we do not have any data on those who did return the survey, we do not know whether those who responded have the same characteristics as those who did not answer the survey. Also, it is not clear whether our results can be generalized to other communities. Still, we clearly demonstrate that both pediatric residents and community physicians are not getting the training they need to effectively screen for DV. We suggest that if the AAP recommendation of DV is going to be ac-

cepted, greater efforts must be made to educate pediatric residents and community physicians.

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THE NEW RELIGION

If there is anything we have learned by observing humans consuming, it is that the least of their concerns is laying up goods. Shopping is far more complex. Along with getting the goods, it is a social activity, an epistemological activity, and even a religious activity.

Twitchell JB. *Lead Us Into Temptation.* New York, NY: Columbia University Press; 1999

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